STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87449-001**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 10th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 29, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on February 5, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on February 19, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On June 14, 2007, the Petitioner underwent temporomandibular joint (TMJ) arthrocentesis surgery. These services were provided by XXXXX, a nonparticipating provider. The Provider charged $700.00 and BCBSM paid $69.94 for this care.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on November 20, 2007, and issued a final adverse determination dated November 28, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgical services provided to the Petitioner on June 14, 2007?

IV
ANALYSIS

Petitioner's Argument

Before her TMJ surgery on June 14, 2007, the Petitioner says she contacted the BCBSM customer service department by telephone and was told that her claim would be processed like an out-of-network benefit. However, she says BCBSM failed to tell her that its approved amount for the service might be less than the amount charged by the provider.

The Petitioner told BCBSM that the oral surgeon was charging $710.00 for her care. Since she has a $250.00 deductible and a 20% copayment for non-network care, BCBSM indicated she would be required to pay $342.00. This would mean that $368.00 would be paid by BCBSM.

The Petitioner paid the full amount charged to the oral surgeon for her surgery. However, BCBSM only paid $69.94 to the Petitioner for this care. The Petitioner does not dispute what the certificate says about how BCBSM should pay for this surgery. However, she believes that BCBSM is required to pay the $368.00 its representative said it would pay for her care.

The Petitioner also believes that it is unfair that there are no oral surgeons in BCBSM's network in the area where she lives, making it impossible for her to use a participating provider.

The Petitioner believes that under the circumstances BCBSM should pay significantly more for her surgery.

BCBSM's Argument

BCBSM says it correctly paid for the services the Petitioner received from a nonpanel provider.

Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonpanel and nonparticipating providers.[1] It says that BCBSM pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full. In addition, since the oral surgeons in this case do not participate with BCBSM, they are not required to accept BCBSM's approved amount as payment in full.

The amounts charged by surgeons and the amounts paid by BCBSM for the June 14, 2007, surgery are set forth in this table:

Procedure Code	Nomenclature	Amount Charged	BCBSM's Approved Amount	Amount Paid by BCBSM	Amount to be Applied to Non-Panel Deductible
20605	Intermediate Joint or Bursa	$ 403.00	$ 69.94	$ 69.94	$ 69.94
D9241	Moderate Sedation	$ 297.00	$ 122.33	$ 0.00	$ 0.00
Totals		$ 700.00	$ 192.27	$ 69.94	$ 192.27

BCBSM says it paid the $69.44 approved amount for procedure code 20605 to the Petitioner in error because that amount should have been applied to the out-of-network deductible. However, BCBSM says it will not recover this payment.

Procedure code D9241, the Petitioner's sedation, was denied by BCBSM as integral to the primary service since the provider did not indicate a modifier of 59. However, if the modifier 59 had

[1] As a nonparticipating provider, the surgeon is by definition also a nonpanel provider.

been filed by the provider, the $122.33 would have been applied to the Petitioner's out-of-network deductible also.

BCBSM says its maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region.

BCBSM contends that it has paid more than it is required to pay for the Petitioner's care by a nonpanel provider and is not required to pay more.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate explains this (on pages 4.26 – 4.27):

> When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and a copayment for most covered services….
>
> * * *
>
> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. * * *
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid its full approved amount of $69.94 for the surgical procedure even though it should have been applied to the non-panel deductible. BCBSM denied coverage for the sedation during the surgery because the proper modifier was not filed by the surgeon. However, even if

BCBSM had approved this procedure the $122.33 would have been applied to the Petitioner's nonpanel deductible and no additional reimbursement would have been due the Petitioner.

Nothing in the record establishes that the Petitioner met any of the exceptions that would waive the nonpanel sanctions, e.g., when the service is the initial exam to treat a medical or accidental injury, or when the Petitioner is referred to a nonpanel provider by a panel provider.

It is unfortunate that the Petitioner was not able to use a participating provider. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate or state law that requires BCBSM to pay more than its approved amount (minus the nonpanel sanctions) to a nonparticipating provider, even if no participating provider was available or even if the Petitioner was not aware that BCBSM only pays an approved amount for covered services.

Finally, the Petitioner's authorized representative says (in his February 12, 2008, letter) that the Petitioner's appeal "is not based on what the contract said, but rather on what the Customer Service Representative told [the Petitioner]." The Petitioner believes that BCBSM informed her in telephone conversations that it would cover all but $342.00 of the charges for her surgery on June 14, 2007. BCBSM denies that it misinformed the Petitioner, saying that its records of the telephone inquiry show that no specific payment amounts were indicated.

In a review under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. Resolution of the factual dispute described by Petitioner cannot be part of the decision here because PRIRA process lacks the hearing process necessary to make findings of fact based on evidence such as oral statements, and in any event the Commissioner lacks the authority (which the circuit court possesses) to order relief based on such doctrines as estoppel or waiver.

The Commissioner finds that BCBSM properly processed the Petitioner's claims according to the terms and conditions of the certificate and is not required to pay more for her care.

V
ORDER

BCBSM's final adverse determination of November 28, 2007, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care provided on June 14, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.